August 14, 2002

TO: James P, Mayer, Executive Director
Toby Ewing, Project Manager
Little Hoover Commission

FROM: Carol Brown
CHDP Deputy Director
City of Berkeley

SUBJECT: Status of California's Children in Foster Care

I am thankful for this opportunity to provide input on the current status of foster children in California, and the changes that have occurred within the last three years to improve access to health care for these children. I will focus on the delivery of health care services, but am strongly aware that foster care reform covers a wide range of needs, each important, each requiring review and ongoing oversight.

The positive changes seen in the delivery of health and mental health services in the past two years were strengthened by the addition of public health nurses who now work side by side in the county with child welfare workers and probation officers. This collaboration, as recommended in Code Blue, lead to an increase in foster children receiving preventive health, dental and mental health services. Since the last Little Hoover report, Now in Our Hands: Caring for California's Abused and Neglected Children, changes in Medi-Cal policy and new legislation have occurred to solve some of the access issues to health care services. These changes provided foster care workers hope for an easier process to timely health care for California's foster children. Public health nurses working across the state have been able to identify health care barriers that continue to exist for foster children, as they work with foster parents and health care providers to navigate our fragmented systems. I would like to speak to some of the barriers that are the result of the following issues:

Access to Medi-Cal Eligibility

Advocates were successful in working with state Medi-Cal staff to create policy change to address three common barriers to obtaining Medi-Cal eligibility for foster children. The barriers solved were as follows: receiving immediate Medi-Cal after the detention hearing, removing an edit for other health insurance so that Medi-Cal could be billed for health services, and the ability to disenroll a foster child from a County Organized Health System Health Plan if the child was placed outside the county served. All County Letters were sent out reporting all of the stated policy changes, but most of the foster care workers are not aware of the changes, and if they are, they do not know whom to contact to make the needed changes. For those of us that work within the foster care system, we realize there is not a system in place to assure that policy change, once achieved, will reach the foster care workers or their supervisors. Training at all levels regarding new

policy needs to occur at both the state level for staff responsible for implementation of new policy, as well as county program managers and front line staff responsible for the medical case management of the foster child. Most recently, public health nurses across the state, have documented on the Child Health Care Access Problem Identification Form, many of the issues in accessing health care services that advocates and state staff felt were corrected. A systems change is needed to assure that child welfare workers, public health nurses, and probation officers receive updates and appropriate training on policy changes that have been put in place to improve access to health care for the foster children they serve.

Access to Orthodontia and Specialized Dental Care

Most of the children seen in California's foster care system receive primary dental care. In fact, the data shows foster children utilize the dental system more often than other Medi-Cal children. The problem arises when the general dentist sees the foster child and identifies serious dental disease, and due to limited resources a referral to specialty care is not possible. Specialists are not willing to see children on Medi-Cal as the reimbursement for specialty dental care is extremely low. Dental advocates were successful in obtaining an increase in specialty dental services f/y 2000, but most likely these increases, due to budget cuts, will be eliminated. The end result is that the general practitioner is faced with providing very complex dental care to the foster child or the child slips through the cracks and does not receive the treatment required.

Increasing the Number of Providers That Serve Foster Children

As stated in Code Blue " there is an insufficient number of pediatric medical, dental and mental health providers who will accept Medi-Cal patients. There are even fewer providers willing to serve foster children because of the time and intensive services their complex conditions often require. Many practices are not equipped to handle the complex psychosocial and medical problems of children in foster care." This issue has not changed. In fact in some regions the problems have become worse. Although providers that see children on Medi-Cal, were given an increase for their services last year, the first in approximately 15 years, it has been suggested, due to the budget shortfall, that the increase be eliminated. Further, over the past few years, additional disincentives to provide care have been identified. There are more required forms for the courts as well as other programs that foster children need completed. Providers are often called to testify at court on behalf of the foster child taking them away from their busy office schedules. The state needs to provide adequate and timely reimbursement for the comprehensive services that foster children require.

Access to Mental Health Services

I feel it is appropriate to conclude my input today, with a discussion regarding access for foster children to mental health services. I will address the barriers which child welfare workers, public health nurses, and probation officers confront each day. Documentation from public health nurses across the state highlights the dramatic need for more child psychiatrists that will serve the foster care population that have high levels of mental health needs. The public health nurses state they are seeing higher numbers of infants and toddlers with mental health needs, but report that the numbers of providers to serve this population is small. Low reimbursement rates, coupled with a lack of providers trained to serve this population leads to longer intervals before toddlers are seen for needed services. Recognized barriers to expanding provider resources for infants and toddlers include the need to adopt the infant mental health diagnostic codes, and a willingness to expand the Early Periodic Screening Diagnosis and Treatment (EPSDT) funding to meet the medical necessity mandates for foster children.

Mental Health Managed Care, created to serve the Medi-Cal population presents problems for foster children placed outside their county of residence. Value Options, the mental health administrative services organization was created to manage the provision of specialty mental health services for children ages 0-18, who have been placed out -of – county in kinship care, and in group and foster homes. All but five counties in California participate in this program, but educating the child welfare workers, public health nurses, and probation officers to access this service has been slow. The oversight to this contact is good, but Value Options faces the same problems recruiting providers as the local plans due to reimbursement rates.

Thank you again for taking the time to evaluate our progress in reforming the system for the most at risk children in California. Please feel free to contact me at 510-981-5308 or cbrown@ci.berkeley.ca.us if you would like further information.

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cc: Verdie L. Thompson, Manager of Health Promotion